

FILED MAR 29 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8474

State File No. ....

0470

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. ....		REG. DIST. NO. <u>144</u>		PRIMARY REG. DIST. NO. <u>4233</u>		Registrar's No. <u>2</u>	
1. PLACE OF DEATH a. COUNTY <u>Iron</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Iron</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Arcadia</u>		c. LENGTH OF STAY (In this place) <u>28 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Arcadia</u>		0470	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>Washington</u> c. (Last) <u>Hull</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 12 1950</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Jan. 20 1907</u>	
9. AGE (In years last birthday) <u>43</u>		10. IF UNDER 1 YEAR (Month) (Day) <u>1 22</u>		10. IF UNDER 1 HRS. (Hour) (Min.)		11. BIRTHPLACE (State or foreign country) <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Field. Supt. R. R.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>cross tie production, Ellington Mo.</u>			
11. BIRTHPLACE (State or foreign country) <u>0</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>George W. Hull</u>				13b. MOTHER'S MAIDEN NAME <u>Carrie Elizabeth Copeland</u>			
13c. NAME OF HUSBAND OR WIFE <u>Ruth Waldram Hull</u>				14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>494-09-2185</u>			
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ruth Hull, Arcadia Mo.</u>				17. ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Metastasis of Cancer of Colon</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of Colon</u> DUE TO (c). II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1538</u>			
19a. DATE OF OPERATION <u>1948</u>				19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Spleen, Thymus of Colon</u>			
19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20. DATE SIGNED <u>3-4-50</u>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>1949</u> to <u>3-12</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>3-12</u> , 19 <u>50</u> , and that death occurred at <u>6.25A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. J. M. Jones</u>				23b. ADDRESS <u>Iron Mountain Mo</u>			
23c. DATE SIGNED <u>3-4-50</u>				23d. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>3-14-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Arcadia Valley Memorial, Ironton Mo.</u>		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>Mar. 16, 1950</u>		REGISTRAR'S SIGNATURE <u>Mrs. Lois Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>White Funeral Home, Ironton Mo.</u>		ADDRESS <u>0</u>	

RECEIVED

MAR 28 1950

DISTRICT HEALTH OFFICE No.

File No. 350-457

APR 4 1950

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Russell J. White

Licensed Embalmer No. 3012

P. O. Address Amritsar, India

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.